

ILLINOIS DEPARTMENT OF CORRECTIONS

Offender Outpatient Progress Notes

Menard Correctional Center

Offender Information:

Gharrett

Last Name

David

First Name

ID#: M38621

MI

Date/Time	Subjective, Objective, Assessment	Plans
7-8-16	1st <u>RN Note</u> / CMT Note 2nd Date: <u>7-8-16</u> Time: <u>9 AM</u> 3rd Tubersol 0.1cc Intradermal Left Forearm 4th LOT # <u>C4860BA</u> 5th Expiration Date: <u>1-5-2018</u> 6th Given By: <u>Jana South RN</u>	
7/18/16	Psych Notes: 4 ⁵⁰ PM S: Scheduled on N2 PCL today O: Refused, not seen A: Needs to be seen	P: Resub. Surgeon 7-18-16
7/31/16	Psych Notes: 2 PM S: Scheduled on N2 PCL today O: Refused X 2 A: Needs to be seen	P: Resub. Surgeon [Signature]

ILLINOIS DEPARTMENT OF CORRECTIONS

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Offender Information:

G. Lassett
Last NameD. Lassett
First Name

ID#: M38621

Date/Time	Subjective, Objective, Assessment	Plans
9/12/16 10:25 AM	Psych note: See Doc 0282 of history data	Surgery L ¹² -DND
11/21/16 10:25	NP NOTE S/O: IM seen in FA following altercation with all Reports he was hit from behind a fist facial trauma to Rt side face/eye & Rt post scalp laceration to H eye - steri strip. Denied LOC. Oral-intact. Unable to ^{open} eye ALT RT swelling. Pain 5/10. Neuro intact. a: Head trauma	P. XRAY skull - Tetanus O.S. eval - IM now - Traumatic looking post - Send to CMH ER for further eval & CT Discharge & FID

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Contusions

Offender Information:

Jharrett
Last NameDavid
First NameID#: M38621
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Date/Time	note: Subjective, Objective, Assessment	Plans
11/21/16	S) - What caused the injury (accident, work related, assault, self-inflicted) <u>assault</u>	(P) MD Referral (call MD) if <u>Tindall @ bedside</u>
1005a	- Where did it happen <u>in cellhouse</u>	- If the wound is over a joint
	- What time <u>about 10 min ago</u>	- Any impairment of function
	- Any history of excessive bleeding <u>φ</u>	- Poor peripheral pulses
	O) <u>97b 88 R 18 BP 140/90 WT</u>	- Any assault wound to the head, face, chest, abdomen or back
	- Medications – are you on a blood thinner <u>no</u>	- Associated syncope or loss of consciousness
	- Pain on a scale of 1-10 <u>5/10</u>	- If injury is self-inflicted, refer to Mental Health
	- Note area of injury	- Nurse uncertain as to extent of injuries
	- Size <u>posterior scalp 8 x 5 1/2 cm</u>	Nursing Intervention (verify medication and allergies prior to treatment)
	- Presence of any bleeding <u>~3 1/4 cm laceration to</u>	✓ Apply cold pack to minor contusions x 12 hours PRN
	- Serious drainage <u>φ</u>	- Acetaminophen 325 mg, 1 – 2 tablets t.i.d. PRN X 3 days (18 tablets) OR
	- Swelling <u>left lower lip</u> <u>posterior scalp</u>	✓ Ibuprofen 200mg, 1-2 tablets t.i.d. with meal PRN x 3 days (18 tabs)
	Edema	
	- Discoloration of skin <u>purplish red</u>	
	- Assess for any disfigurement or alteration of ROM <u>φ</u>	
		OVER

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Date/Time	Subjective, Objective, Assessment	Plans
11-21-16 11:50P	<p>R/note</p> <p>S-"I can barely open it."</p> <p>O-Returned from Chester Hosp. (L) eye swollen. Able to open eye slightly. (L) side of face also swollen.</p> <p>able to open mouth.</p> <p>Resp. reg. It unlabored.</p> <p>NAD-</p> <p>A-SIP assault, (L) eye head injury.</p>	<p>P-Placed in a pharmacy for 23° obs.</p> <p>V.O- DR. TROST</p>
98 76 18 160 86		
12/7/16	R/note	
10AM	<p>S: am ok</p> <p>O: L eye healing well. Denies Pain. SR NO diff C Site. AOK 3. No neuro deficits noted. NAD</p> <p>A/ 3/P Assault</p>	<p>P) P/U in 1 wk</p> <p>Cyrol. issued</p> <p>D/C to Court House</p> <p>(Dette)</p>

Facility:

Last Name

First Name

M

ID#: M 3862

DOC 0110 (EH 3/2002)
(Replaces DC 1705)

Offender information:
 Last Name Sharrett First Name Donald MI ID# 1138621
 Facility: Menard

DOC 0110 (Eff. 9/2002)
(Replaces DC 1705)

ILLINOIS DEPARTMENT OF CORRECTIONS
Offender Infirmary Vital Sign
Graphic Flow Sheet

Offender Information:

Offender Name: Blawett David ID# M 38621
Last Name First Name MI
Facility: Menard

Date	12-2-16	12-3-16	12-4-16	12-5-16	12-6-16
Hospo Day/Po Day	1	1	1	1	1
Hour	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12
Temperature					
105					
104					
103					
102					
101					
100					
99					
98					
97					
96					
Pulse	74	70	80	72	76
Respiration	16	14	16	18	15
Blood Pressure	118/76	110/68	120/86	130/86	122/80
Weight					
Height					
Stools	yes	yes	yes	yes	yes
C-P-T-S					
Hygiene					
PM Care					
Diet					
Ate	W F P	W F P	W F P	W F P	W F P
Slept	W F P	W F P	W F P	W F P	W F P
Activity					
Bed Rest					
Bed positioning					
R.O.M. Exercises					
Whirlpool					
Transfers					
Walk					
Other					
Off Name	Blawett	Blawett	Blawett	Blawett	Blawett
3-11	Blawett	Blawett	Blawett	Blawett	Blawett
11-7	Blawett	Blawett	Blawett	Blawett	Blawett

ILLINOIS DEPARTMENT OF CORRECTIONS
Offender Infirmary Progress Notes

Menard

Center

Offender Information.

Garrett
Last NameDavid
First Name

ID#: M38621

Date/Time	Subjective, Objective, Assessment	Plans
11/22/16	<u>DOCTOR INFIRMARY ADMISSION NOTE</u>	PLAN:
0900	BY: (circle one): MD NP PA DDS LICENSED MENTAL HEALTH PROFESSIONAL	VITAL SIGN FREQUENCY: 2 shift
	ACUTE CHRONIC	
	<u>SUBJECTIVE:</u>	DIET: regular
	HISTORY:	ACTIVITY: as tol
	I'm assaulted and suffered facial fractures.	MEDICATION ORDERS:
	DURATION: 24°	ultram 100mg PO BID PRN x 1wk tylenol 500mg 4-6 PO Q6° x 1mo
	<u>OBJECTIVE:</u>	
	PHYSICAL EXAMINATION:	
	Alert, NAD. Mod to marked @ facial swelling chest clear, BS=	
	Candida RAR	OTHER ORDERS: 1000mg 11/22/16 Jen
	CURRENT CONDITION:	
	fair	
	OTHER MEDICAL CONDITIONS:	
	none	
	ADMITTING DIAGNOSIS:/ASSESSMENT	
	multiple trauma facial fractures	

Distribution: Offender's Medical Record

Printed on Recycled Paper

DOC 0086 (Rev. 9/2002)
(Replaces DC 744)

ILLINOIS DEPARTMENT OF CORRECTIONS
Offender Infirmary Progress Notes

Menard

Center

Offender Information:

Shanett

Last Name

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ID#:

M38627

Date/Time	Subjective, Objective, Assessment	Plans
11/22/16	INFIRMARY NURSE ADMISSION NOTE: <u>ACUTE</u> CHRONIC	<u>PLAN:</u>
9AM	<u>SUBJECTIVE:</u> Chief Complaint Left Orbital fx	MD NOTIFIED: DR. TROST HCUA NOTIFIED: DIETARY NOTIFIED: TYPE OF DIET: Regular FORM SENT TO DIETARY
	Duration:	MEDICATION ORDERS
	<u>OBJECTIVE:</u> BP 140/70 97 P 80 R 16 WT Oxygen Saturation: 98% Peak Flow: 1 Na 2 Na HEART: R R R LUNGS: Clear	PR MAR Isoniazid 500 mg PO. q 6 ^o x/mo Vitamin 100 mg PO. tid x/wk Erythromycin oph Oil XtHulu
	EYES: (circle) WARM MOIST DRY CLAMMY SKIN: (circle) WARM MOIST DRY CLAMMY SKIN COLOR: Natural SPEECH: (circle) CLEAR SLURRED MOBILITY: ambulates ELIMINATION: WNL MENTAL STATUS: AOK 3	OTHER ORDERS: R/T Nausea
	ASSESSMENT/NURSING DIAGNOSIS: alt Confect	TREATMENT: ACTIVITY: Up as Tol. ORIENTATION TO THE INFIRMARY RULES, CALL FOR HELP, PLAN OF CARE OTHER: [Signature]

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Date/Time	Subjective, Objective, Assessment	Plans
11/22/16 9 AM	Ru Note S: I'm in pain. O: Offender DOX3 C/O Pain R/T FX Ocular. Denies N/V Hand grips strong walk C/steady gait. NAD Noted. P) All Compact R/T FX ocular	P) cpr
11-22-16 3:30 PM	Ru Note S: / O: I'm sitting upright or bed. A/C x3. Cooperative I'm no Distress. Respirations equal/unlabored. Eating dinner A: All in Comp Post R/T FX	P. cpr

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ID#: M38621

Date/Time	Subjective, Objective, Assessment	Plans
11-23-16	pr Note	P. CR
3:15 p	S: 4	
	O: 8 (a) sitting upright on	
	bed eating Dinner 5	
	Issues None, Cooperative.	
	T- no distress at this	
	time, otherwise stable note.	
	Respirations even/unlabored.	
	A: All in Comfort	
	ALT T- 50%	
	AD Note	
11-24-16	S- "OK"	P-CRM
400 p	O- 155 - Tramadol for pain	
	(1) side of face swollen	
	Brined. Can open eye	
	Small ant, A+Ox3. resp	
	even/unlabored	
	A- alt in comfort/facial fx	

Pam Hannon

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Date/Time	Notes	Subjective, Objective, Assessment	Plans
11/24/10	S) "I'm dizzy"	P) C-P.M.	
10A	<p>O) I/M A/D x3 gait steady resp even / unlabored skin W/D I/M able to open both eyes focusing / swelling noted to @ orbit I/M denies any blurred vision in @ eye I/M denies any pain @ this time V.S.S. @ acute discom noted</p> <p>A) Alt in comfort K/T facial injury</p>		

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Offender Information:

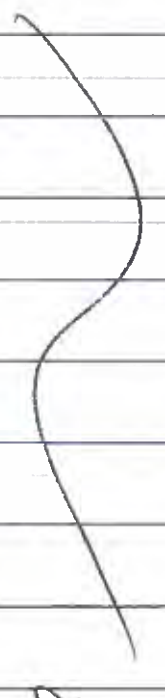
Gharrett David

Last Name

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ID#: M38621

Date/Time	Subjective, Objective, Assessment	Plans
11/24/16	S) "I'm good"	P) C.P.M.
1530	<p>o) I/m A/D x3 got steady resp even/unlabored skin w/D ⊙ orbital remains swollen/ Irruised I/m denies any vision changes denies blurred vision Neuro intact I/m voices & complaints & acute distress noted</p> <p>A) All in comfort R/T facial injury</p> <p>Rw Date S-"Getting better I can lay on that side"</p>	
11/25/16	<p>350A</p> <p>o- Got steady. Day still red blood to bruising & swelling ↓ Resp even/unlabored C/P acute distress</p>	P-CPM

All in comfort R/T facial fx

Pam Hennen

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Date/Time	Subjective, Objective, Assessment	Plans
11-25-16	W Note	1:10 PM
3:15 PM	<p>S: "I'm all good"</p> <p>O: F/M sitting upright on bed eating Dinner 5</p> <p>I: Issues I - no Distress</p> <p>C: this time, speaking clear speech. Respirations even/unlabored</p> <p>A: Alt in comfort w/ IT 12</p>	
11-26-16	Primate	1:10 PM
1:25 PM	<p>S: 5-8</p> <p>O: Resting quietly. Resp. regular/unlabored. No Chv. NAD</p> <p>A: Alt. in comfort w/ IT</p> <p>facial injury.</p>	Thamett

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Date/Time	Subjective, Objective, Assessment	Plans
11-27-16	Private	P.C.M.
1A	S-O	
	O - Resting quietly. Less edema noted @ side of face. Resp. reg. it was - favored NAD.	
	A - all in comfort R/T @ orbital fx.	Monitor R
11/27/16	RA N/A	
10A	S) "I'm ok"	P) C.P.M.
	O) I/M A/OX 3 put steady resp even/unlabored & edema to @ orbital, bruising noted. Also N/D I/M voice & complaints & acute distress noted.	
	A) All in comfort R/T @ orbital fx.	

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Date/Time	Subjective, Objective, Assessment	Plans
11/27/16 4pm	RN Note S-Q'm OK O - \emptyset 4% roved \emptyset ADU A/O x3 gait steady Resp E/L edema continuous to (2) orbital & bruising Skw W/O/I A - Act. in comfort R/L(L) orbital	P - CPM T. Arhitz
11-28-16 1235A	RN note S x O - Resting quietly, Resp. reg. it undisturbed. Facial swelling & discoloration decreased. No C/O. NAD A - Act. in comfort R/L (L) orbital fx.	P - CPM D. Muttin

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ID#: 14 38621

Date/Time	Subjective, Objective, Assessment	Plans
11-28-14 8:25	<p>③ Flu assault to O.S. injury.</p> <p>④ Vitals stable, facial swelling decreased. Scelus still blood red.</p> <p>PELLA - GOMI</p> <p>④ O.S. Trauma</p>	<p>④ no changes</p> <p>Calculated</p> <p>Woke 8:00am 11/28/14 8:00am</p>
11/28/14 9am	<p>RN Note</p> <p>S: see above.</p> <p>O: Offender Resting on Bench, No C/O voiced. Swelling to left side face improved. Left eye remain red. Denis blurred vision. AOK 3.</p> <p>A) all Comfort R/T Orbital Fx</p>	<p>P) Cpm</p> <p>Shanett</p>

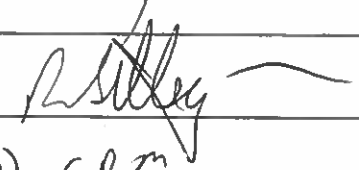

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Offender Information:

Shawett Shawett ID#: M38621
 Last Name First Name MI

Date/Time	Subjective, Objective, Assessment	Plans
11/28/16	RN Note	P) CPM
4:00 PM	<p>S) "Lm OK."</p> <p>C) 1 per self 5 difficulty. Hx 3. Sup e/n. & 9/5 of dexten noted & 40 varied. Ready book</p> <p>Moderate amount of edema noted to (L) sub / fore. Edema at brow noted to (L) orbital.</p> <p>Sclera bright red to (L) eye.</p> <p>Denies Visual deficit. PERLA.</p> <p>VSS. Cooperative.</p> <p>A) Aet = Comfort R/T orbital fx</p>	
11/28/16	RN Note	P) - CPM
11:10 PM	<p>S) "Lm fine."</p> <p>C) Awareness clearly. Hx 3. Sup e/n. & 40 varied - & 9/5 of dexten noted VSS. Edema remains to (L) sub / fore.</p> <p>(L) eye sclera remains bright red swollen</p> <p>(L) orbital note. Remain not for - Cooperative.</p> <p>A) Aet = Comfort R/T orbital FX</p>	

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Date/Time	Subjective, Objective, Assessment	Plans
4/29/16	<p>MD Note</p> <p>SOA's no op's</p> <p>Alert, oriented</p> <p>↓ facial swelling</p> <p>FX lwh = ENT, opth</p> <p>Δ status to chronic</p> <p>noted 11/29/16</p>	
11/29/16	<p>RN Note</p> <p>0845 S) "I'm good"</p> <p>O) I'm A/D x3 just steady</p> <p>resp. even/unlabored skin w/p</p> <p>minimal swelling noted (L)</p> <p>orbital, bruising remains to</p> <p>(L) orbital I/M nases &</p> <p>complaints & acute distress</p> <p>noted</p> <p>A) status Δ to chronic</p>	<p>P) status Δ to chronic</p> <p>as ordered</p>

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Date/Time	Subjective, Objective, Assessment	Plans
12-1-16	R/note	P/CPM.
110A	S-O	
	O-Resting quietly. Resp. reg. it unlabored. No chlo.	
	NAD.	
	A-Chronic S/P @ orbital	
	fx.	Monitor
12-2-16	R/note	P/CPM.
1245A	S-O	
	O-Resting quietly. Resp. reg. it unlabored. Decreased swelling & discoloration of face.	
	A-Chronic - R/H facial	
	Orbital injury.	Monitor

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Date/Time	Subjective, Objective, Assessment	Plans
12-3-16	R/note	P-CFM
12-25A	S-ø	
	O-Resting quietly. Resp.	
	reg. it unlabored. Recent	
	swelling & discoloration	
	decreased. No CIB. NAD.	
	A-Chronic RT (C) orbital/	
	focal injury.	Munich
12-3-16	R/note	
12-25A	Health status done for ENT F/W appt. on	
	12-6-16.	
		Munich

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Date/Time	Subjective, Objective, Assessment	Plans
12/3/16 8 AM	RN Note S: 0 O: appears to be asleep. Keep E & U. No C/O Voids @ this time. NAD noted. A) Chronic RIT (Dorsal) myelitis injury	P) CPM
12/4/16 3:50 AM	RN Note S) "bin good." O) 1X shunt for med and am meds. No x3. Pup E/U. 6/5/s of direction noted - Biting/cracks to L jaw/orbit much improved. & C/O voids. Dorsal med. A) Chronic RIT (L) eye injury	P) - CPM R left

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Date/Time	Subjective, Objective, Assessment	Plans
12/5/16	RN Note	P) - CP m
4:00 AM	<p>S) "Thud - gm."</p> <p>O) Awake easily. Hx 3. Reg^e 1/2.</p> <p>& 1/2 / duction noted & 1/2</p> <p>Voiced - Barring / edum to</p> <p>① four / obdctd sentences to</p> <p>improve. Denon visual deficit</p> <p>A) Chronic R/L ② eye injury</p>	
12-6-16	RN Note	
1:40A	<p>S &</p> <p>O - Resting quietly. Reg^e 1/2.</p> <p>reg. it unlabeled. No clo.</p> <p>NAD</p> <p>A - Chronic R/L facial</p> <p>trauma.</p>	<p>P - CP m.</p> <p>David</p>

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Date/Time	Subjective, Objective, Assessment	Plans
12-6-16 625A	RN note S-Ø Ø-Escorted from Hou by Security. A-Med. furlough	P-Proceed - ENT follow-up. Shanett Ø
12/6/16 1330 974 84 16	RN Note S) med furlough return Ø I/m A/O x 3 resp even unlabored sleep w/Ø I/m	P) MD to see on AM rounds T.O. Dr. Trust / Ø
12/8/16 982	noises & complaints V.S.S. Ø acute distress noted A) med furlough return	IX noted 12/6/16 Ø
12-7-16 1 AM	RN Note S-Ø Ø-Resting Quietly Ø ADNI Ø % voiced Resp/EU A-Chronic H/facial Trauma	P-CPM T. A. Ø

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Offender Information:

<u>Gharrett</u> Last Name	<u>David</u> First Name	<u>MI</u>	ID#: <u>M38624</u>
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Date/Time	Subjective, Objective, Assessment	Plans
12/1/16	MD Note	
9:45 PM	50A's to ops. No vision ops. Social demands reduced.	Pc 1/2 to call house ✓ FD 7-10 days
		Notes 12/7/16 10 AM

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Date/Time	Subjective, Objective, Assessment	Plans
12/1/16 945AM	INFIRMARY DISCHARGE SUMMARY BY: (CIRCLE) MD DENTIST PSYCHIATRIST	INFIRMARY DISCHARGE ORDERS:
	ADMISSION DATE: 11/22/16	continue present meds ✓
	DISCHARGE DATE AND TIME: 12/1/16	diet, activity as tol
	ADMITTING DIAGNOSIS:	
	orbital fracture	
	DISCHARGE DIAGNOSIS:	
	same	
	INFIRMARY COURSE:	FOLLOW UP PLAN:
	Admitted 11/22/16 @ ①	7-10 days ✓
	orbital rim fracture related to assault. Injury evaluated by ENT, ophthalmology. No surgery required. DC'd to cellhouse 12/1/16.	

[Signature]
 12/7/16
 1012

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12/27/16 12:10 PM	Psych Notes: See Doc 0502 of 12/27/16 data	Surgeon noted differential 12/27/16 4:10 PM
1/8/17	MD Note SoA Release any/all med holds	Pc
		Michael 1/8/17 Dance
1/24/17	Psych Note: See Doc 0502 of 12/27/16 data	Surgeon

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Offender Infirmary Progress Notes

Manu d Center

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M 38621

Date/Time	Subjective, Objective, Assessment	Plans
12/7/14	RN/LPN Infirmary Discharge Summary	P.
10AM	S. Summary of reason for Admission:	Diet on discharge: <u>Regular</u>
	<u>F/x ocular</u>	
		Activity on discharge: <u>Regular</u>
		<u>as tol</u>
	O. T <u>98</u> P <u>74</u> R <u>14</u> BP <u>114</u> WT <u>74</u>	Treatment and medications on discharge: <u>Tylenal 500mg $\frac{1}{4}$ - $\frac{1}{2}$</u> <u>P.O. q 6° PRN</u>
		Return Follow-up: <u>Flu in 1wk</u>
		Patient Education: <u>No fighting</u>
	A.	<u>Take pain med per order PRN</u>
	Admitting DX: <u>Fx ⁽²⁾ ocular</u>	Discharge Location: <u>W 504</u>
	Nursing DX: <u>acc Comp</u>	Nurse Signature: <u>(Shanett)</u>
	<u>RIT Fx</u>	

